Report of the Independent Review Of the Care and Treatment of [redacted]

A report commissioned by
Hampshire Strategic Health Authority
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PREFACE

I was commissioned in October 2006 by Hampshire Health Authority to undertake this independent inquiry.
Herewith is my report, having followed the terms of reference and the procedure which was issued by the authority at the time of commissioning.

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Documentation

- Medical records for [redacted].
- Medical records for [redacted] dated.
- Critical incident review
- Police statements from [redacted]
- Correspondence relating to the critical review.
- Policies, all Hampshire partnership, NHS trust current at the time of the incident

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5.1.1 Chapter One

5.2 1. INTRODUCTION

1.1 On 2 December 2004 both [redacted] and [redacted] met their deaths at [redacted] at around 6am.

1.2 [redacted] had been in receipt of mental health services from Hampshire Partnership NHS Trust since 1993. He was under the care of Dr [redacted], Consultant Psychiatrist and was supported by the Assertive Outreach Team at the time of the incident.

1.3 [redacted] was also in receipt of services from Hampshire Partnership NHS Trust since 1993 and had been seen initially by Dr [redacted] and more recently by Dr [redacted].

1.4 Hampshire Partnership NHS Trust carried out a full local serious untoward incident inquiry chaired by Mr. Andy Newland. This included interviewing the relatives of both [redacted] and [redacted] and staff involved with their care.

1.5 Following this, an independent inquiry into both patients' care and treatment has been carried out in order to learn lessons for the future.

1.6 Terms of Reference and Procedure for the Inquiry are included in Appendix A.

1.7 My sympathy goes to the bereaved families of both Mr. [redacted] and Mr. [redacted] who have suffered and continue to suffer the uncertainty of not knowing how or why these deaths happened.

1.8 I am satisfied from the evidence available that both [redacted] and [redacted] suffered from a mental illness, which was evident at the time of their deaths. At the time of their last contact with services, both men were symptomatic.

1.9 From the evidence available, it is unclear as to the course of events on the morning of their deaths. It would appear that [redacted], having been reluctant to take medication, had become unwell, but did not display signs or symptoms, which would have suggested that he was sectionable.

1.10 [redacted] been difficult to engage, but at the time of his death symptoms of his illness were under control, with the use of medication. [redacted] had a history of aggression and violence, particularly when he had been abusing drugs or alcohol.

1.11 It is noted in Dr [redacted] statement to the police that [redacted] had in passing mentioned [redacted], as a friend who he saw on occasions. They had known each other during childhood and from various admissions to hospital.

1.12 In the statement from [redacted], he expressed concerns that [redacted] had always struck him as being a suicide risk despite everything he [redacted]) said being to the contrary. He said his concerns were raised because of [redacted] brother's suicide and [redacted] high degree of social isolation. [redacted] always appeared to him as a gentle character, and he had no concerns that [redacted] would harm anyone.

[redacted] A full critical incident review was undertaken following the deaths of [redacted] and [redacted] [redacted]

Chapter Two
2. [redacted] – Psychiatric History

2.1 [redacted] was first referred to services as an adolescent during his first year in 6th form at school. He was depressed and preoccupied by feelings of inadequacy particularly about his small stature. He also appeared to have difficulty in relating to his parents. He was seen in November 1993, for an assessment by a psychologist, who went on to provide several sessions of therapy.

2.2 [redacted] was diagnosed with a psychotic depressive illness in 1995, following a further referral by his general practitioner, after which he remained in contact with psychiatric services until the time of his death.

2.3 History

[redacted]. There was no history of psychiatric illness in the family, although it later emerged that his brother had also received treatment for depression. [redacted] appeared to have had a normal childhood until he reached the age of 17. His grandmother's death when he was 13 appeared to have had an impact on him, transforming him from a quiet but popular boy into a depressed worrier. He had been present at his grandmother's death and criticized himself for the way in which he dealt with it.

2.4 He was brought [redacted] and attended [redacted] Schools leaving with nine O levels and two A levels despite his difficulties around that time. He was diagnosed by his GP Dr [redacted] as being depressed during his lower 6th form year and was prescribed Fluoxetine (an antidepressant) which he stopped of his own accord in March 1994. He was referred to [redacted], clinical psychologist who saw him between September 1993 and May 1994. During these sessions [redacted] expressed nihilistic ideas and problems in relating to his parents.

2.5 First Admission

[redacted] was admitted to [redacted] Hospital, following an emergency assessment by Dr [redacted]. He had been at [redacted] for a few weeks studying environmental protection. **T**he warden saw him leaving college at 1am on a Tuesday morning. He informed the warden that he was leaving college and he was advised to speak to his parents. His mother received a telephone call from [redacted] around 11am who told her that he had been sleeping in his car and wandering round looking for a job. He was later found by the police, leaning over a bridge and they were concerned he was going to jump. They took him to the police station from where he was

collected by his parents, seen by the GP and referred for an urgent assessment.

2.6 He was admitted and diagnosed with a psychotic depression. He was agitated, expressing nihilistic delusions and had burnt himself on his arms with cigarettes. Although physically well he appeared dehydrated. He was placed on 1:1 observation and treated with Chlorpromazine (an anti-psychotic) and Diazepam (an anxiolytic).

2.7 [redacted] expressed the belief that he was evil and would go to hell. He thought he had lost his soul and was afraid to kill himself, as he would go to hell.

2.8 He was treated with Lofepramine (an antidepressant) and he consented to a course of 10 electroconvulsive treatments, which improved his mood but did little for his delusional beliefs although these gradually faded. He had increasing periods of successful home leave and was discharged from hospital on 22nd January 1996.

2.9 He was to be seen in the outpatient clinic, was maintained on oral medication and had regular contact with a CPN, [redacted].

2.10 Although he engaged in outside activities he made little progress at home and Lithium (a mood stabiliser) was added to his medication. The family was also being seen by [redacted] for Family Therapy.

2.11 [redacted] care was regularly reviewed through the CPA process.

2.12 He was reviewed by Dr [redacted] in April 1996. William had been reducing his medication, which had resulted in him feeling lower in mood and having occasional suicidal thoughts. He was advised to reinstate his medication. He then continued to make progress, although he developed little insight into his illness. He was referred to [redacted], Clinical Psychologist for individual therapy. Following an assessment, he turned down further therapy stating that he intended to go to Lourdes for a miracle cure.

2.13 Discharge form Services

In December 1996 [redacted] stopped all his medication and remained well. He was seen by Dr [redacted] on 1 May 1997 when he was discharged from follow up.

2.14 Re-referral

He was referred back to Dr [redacted] in July 1997 following the suicide of his younger brother. He had started to relapse and was expressing similar delusional ideas to those on his first admission, however when seen he was apparently better and denied any delusional beliefs. He refused any further follow up.

2.15 Second Admission

In 27 December 1997 he was seen at home by Dr [redacted] who assessed him under the Mental Health Act 1983 which resulted in his admission to [redacted] on section 3. On this occasion he was presenting as hypomanic, overactive, disinhibited and aggressive. He later absconded from hospital and was taken to Withington Hospital in Manchester by the police who had found him wandering. He was transferred back to St James Hospital, Portsmouth on 22 January 1998.

2.16 During this admission [redacted] was treated with Depot medication. He also reported seeing visual hallucinations with a religious content. He eventually left hospital on Section 17 leave on 2 April 1998 on oral medication; Sulpiride (an anti-psychotic) and Procyclidine (a drug to counteract side effects), and was discharged on 22 April 1998.

2.17 Despite repeated advice that it was necessary to continue medication, [redacted] discontinued it towards the end of the year and started to relapse. He then appeared to be willing to restart it but did not take it consistently, eventually stopping altogether in February. He remained stable until June 2001 when he was again discharged from services.

2.18 He was re-referred by his GP in May 2002. [redacted] had been working and living away from home. He had been taking Sulpiride, which had been prescribed by his GP. He was seen again by Dr [redacted] who advised the GP regarding medication, reviewed him and discharged him back to the care of the GP.

2.19 He was seen by Dr [redacted] for an annual review in August 2003. [redacted] was planning to move to Scotland. He was still taking Sulpiride on an intermittent basis and was deemed to be a low risk patient on Standard CPA. He was given an appointment for August 2004.

2.20 [redacted] was seen again on 21 October 2003 following a telephone call from his GP. He was clearly relapsing into a depressive illness with nihilistic delusions but was reluctant to be hospitalized. He was treated at home with support from his CPN, [redacted] and the CMHT. Despite this he was admitted informally on the 25 October 2003. He was discharged home on 4 November 2003 with follow up appointments arranged.

2.21 [redacted] was re-admitted on 24 November 2003, having been referred by the Area Support Team. He

appeared agitated and had been driving a tractor round the farm “crashing into things”. He seemed unable to maintain a logical stream of thought. He was treated with depot anti-psychotic medication and discharged on 9 December 2003. He was readmitted on 27 December 2003 because of increased agitation and poor sleep but responded to an increase in his depot medication and was discharged on 9 January 2004.

2.22 He was followed up in outpatients until the time of his death. His depot medication was changed to Piportil, which made little difference to his underlying delusional beliefs. He continued to help on his father’s farm but lacked drive and motivation.

2.23 In April 2004 he stopped his depot medication. He did not see the need for medication and was seeing a psychotherapist privately on a weekly basis. He defaulted on his next appointment (20 September) and was advised by letter to make contact if he required another.

2.24 Throughout the previous year he had had regular contact with [redacted] from the local CMHT. [redacted] continued to see him until 30 November 2004. This visit was precipitated by a telephone call from [redacted] parents.

2.25 Since stopping his depot medication [redacted] had became aimless and unable to sleep. He'd talked about losing his soul which walls one of his relapse indicators but he did not appear to be depressed.

2.26 Although [redacted] remained medication free he continued to meet with [redacted] and to do on jobs around the farm. He had also been playing golf, which he said he enjoyed. He declined the offer of social activities or a support worker to take him out.

2.27 On 17 September 2004, [redacted] made contact regarding her concerns. [redacted] was going off to various towns without letting anyone know. He had also been driving without using a seatbelt.

2.28 [redacted] declined to take part in the CPA review process. [redacted] had attempted to contact him several times during the week of the 12 November 2004 and finally saw him on 16 November. [redacted] described feeling like "a zombie", shut off from everyone and everything. He was afraid of touching anything because he believed that he might come to harm.

2.29 On 30 November 2004 a crisis visit was made to [redacted] at home following a telephone call from his parents. He had been unable to sleep for two nights and was very agitated. [redacted] wrote in his notes

. " we saw [redacted] on his own. He showed a lot of agitation (he was unable to keep still in the chair) his responses were often slow, but this did not seem to be because of the psychomotor retardation; it seemed to be because of his agitation plus some guardedness on his part, because I was accompanied by a doctor (he fears being admitted). He declined medication at first. He said that it was not a medical thing. He indicated that everything that was happening was his fault for instance, the weather, which was overcast and cold, was his fault. He seemed to have some influence on traffic, but this was unclear at the consultation".

2.30 He was terrified of going to sleep because of the nightmares he was experiencing. He really believed that the dream was true. He was persuaded to take the medication and was prescribed olanzapine (an anti-psychotic), zopiclone (a sleeping tablet) and diazepam.

2.31 The next entry in the case notes is a report of a serious incident, from the police, received on 2 December 2004 that [redacted] had died in the early hours of the morning.

Chapter Three

3. [redacted] – Psychiatric History

3.1 [redacted] was first referred at the age of 25 to the Havant and Petersfield Community Health Care Service in March 1993 by his GP. Since childhood he had had difficulty controlling his anger and this often lead to physical violence.

3.2 Following an assessment by a CPN, [redacted], he was referred on to Dr [redacted], who saw him on 29 July 1993 at home as by that time [redacted] was acutely psychotic. It was not clear at that point whether this was drug related. He was admitted to hospital and remained in contact with psychiatric services thereafter.

3.3 History

[redacted] was born in London and moved to [redacted] when he was 5 years old. He moved back to London at the age of 17 when his parents divorced, returning to [redacted] to live with his mother in 1993. He had one younger sister. He attended boarding school from the age of 11 but was poorly motivated and he left with 6 O Levels around the time of his parents' divorce.

3.4 He went on to work on a farm in Gloucestershire, and then did some building work to earn money for an Arts Foundation course in Camden, which he completed. He did not go on to college as he moved in with a friend and found work editing, then acting as a runner for a post-production company. He was made redundant after a year following which he found work as a production assistant in a film company. After a year he formed his own partnership doing freelance directing. This lasted for 3 years until the company went into liquidation. He continued in journalism thereafter.

3.5 He had a number of relationships with women, two of which lasted two-and-a-half and 3 years respectively. Both were stormy with bouts of violence. He experimented with LSD and cocaine but had only used cannabis in the 4 years prior to his first admission. He drank heavily at times when he described himself as depressed but normally had approximately 7 units twice weekly.

3.6 First contact.

[redacted] was referred by his GP, Dr [redacted], in March 1993. His main problem at that time appeared to be problems with anger and violence, which had been present since childhood. There is a reported episode of violence towards his mother. He had had relationships with two young women where violence contributed towards the end of the relationships. He had also been in conflict with the

law. He was seen one month later for assessment, by [redacted], CPN. Following this, it was agreed that he should see a psychiatrist and he was counselled, regarding his used cannabis and alcohol. Even at this early stage, there were cancellations of appointments.

3.7 Dr [redacted], SHO to Dr [redacted] saw [redacted] on 10 June 1993 and took a full history concluding that [redacted] suffered with recurrent depressive episodes leading to anger and anxiety, and at that time he appeared mildly depressed. He made a referral to [redacted], Clinical Psychologist for assessment and to [redacted] for anger management, following which he was discharged from the outpatient clinic.

3.8 Dr [redacted] saw [redacted] at his home in [redacted], in July 1993. He was clearly acutely psychotic and unable to give a history. This psychotic state had lasted three or four days during which he had not slept. There had been previous brief episodes lasting a day or so, probably related to his drug use. He appeared to be hallucinating, was perplexed and deluded reporting thought insertion and broadcast. There were delusions of reference. It was agreed at this point that he should be admitted to hospital. The working diagnosis was one of a drug-induced psychosis.

3.9 First admission.

[redacted] was admitted on 29 July 1993 and treated with sulpiride (an anti-psychotic) at night. He was detained on a section of the Mental Health Act to during this admission. On the sixth of September he was discharged from [redacted] Hospital, and seen in the outpatient clinic on the 10th. He was due to take up a place at Edinburgh University. The following month, he was advised to postpone his three-year course. However, he was not sure that the course was what he wanted to do. He was advised to obtain further prescriptions for his medication and his GPs but seemed surprised that he would need to continue this. He was seen by his CPN on 22 September, and it was clear that he had not obtained further medication and had stopped five days previously.

3.10 On 17 November, [redacted] informed his CPN [redacted] that he felt he no longer needed to see her. Although frustrated but being unable to find work, he generally felt that he was well. [redacted] was discharged from her caseload but had her contact details, should the need arise.

3.11 He was reviewed on the 23 December 1993, by Dr [redacted], a locum consultant psychiatrist. Although all not psychotic, despite being off medication, [redacted] continued to experience bouts of low mood and problems with sleep. He expressed fantasies about his death included violent death by shooting. He was attending art therapy and counselling with the CPN, which he was finding helpful. In view of the low mood and persistent poor sleep he was given amoxapine.

3.12 A report from the art therapist, [redacted], also recognized "an underlying anger, which is constant, but contained"**.**

3.13 Second admission.

Prior to this admission, [redacted] had lost a job in a local cafe. Following this he disappeared to London and slept rough. Finally appearing at a police station where his parents collected him and brought him home. [redacted] was found the following morning wandering naked in the ground of [redacted] School (his old school). He was detained at Alton police station on section 136 (MHA) and it was thought that he had been using amphetamines. He was unable to give a coherent history. Despite receiving no medication of any kind, the disorder disappeared quite rapidly. He failed to provide a urine specimen for drugs screening. Three days into the admission, it was clear that he had a substantial loss of energy and sense of direction. He also admitted ideas of reference and auditory hallucinations. The impression of was of a grumbling paranoid illness, with brief periods of psychosis relating to upsetting events and drug use. He was restarted medication, but refused to take tablets when he went on home leave. He was transferred to the Old Vicarage, on 17 March 1994.

3.14 He was readmitted to the acute unit on 25 March as he was exhibiting further symptoms of psychosis. He admitted taking cannabis and his symptoms settled within two days of admission. He was recommenced on medication and discharged home on the 29 March.

3.15 Following his admission is attendance at appointments was sporadic.

3.16 Third admission

[redacted] was admitted to the Royal Edinburgh Hospital, on 5 May 1995 following an assessment by the emergency psychiatric team. He appeared suspicious, distressed, and fearful and was probably hallucinating. These symptoms settled rapidly with oral medication, and he was discharged on 8 May. Initially, [redacted] complied with medication and follow up.

3.17 There appears to have been little contact with psychiatric services in Hampshire, whilst [redacted] was at university in Edinburgh.

3.18 Fourth admission.

[redacted] was admitted informally on 10 January 1996, under the care of Dr [redacted]. He was at home for the holidays with his parents and had stopped his medication, but was once again indulging in alcohol and cannabis. He appeared vague on questioning and feared that his father would kill him. He had cut

off his hair in front of his GP, asking for forgiveness. He was recommenced on medication and placed on one-to-one observations. During the admission, he appeared sexually inappropriate from time to time. He also sat reading aloud from the Bible, but did not communicate much otherwise. He reported feeling depressed with auditory hallucinations and passivity. He also believed he was going to hell as he had sold his soul to the devil. He was also experiencing suicidal thoughts on a daily basis. [redacted] was prescribed an antidepressant, in addition to his other medication and was transferred to the Old Vicarage on 14 March, from where he discharged himself.

3.19 He was seen in the patient clinic in early April, when he appeared unwell, but not sectionable. He admitted to having auditory hallucinations again, which were the derogatory in content. He denied any other psychotic symptoms. It was suggested to him that he increased his medication, although it appeared that he had not been compliant with it over the previous few days. [redacted] defaulted on several appointments for following this.

3.20 There is a memo from [redacted], of the CMHT dated November 26, 1996, expressing concern about [redacted] anger. She reported that [redacted] felt like being violent towards someone and she was concerned regarding the safety of other professional colleagues about whom [redacted] expressed both anger and paranoia.

3.21 In December 1996, [redacted] was visited at home as he threatened to smash his parent's greenhouse if he was not allowed into the house. [redacted] own accommodation was untidy and rather smelly. [redacted] main contact at that time was with his CPN. In mid-March, there were reports from [redacted] mother and the police that [redacted] had been breaking windows at his mother's house. On 8 April 1997, [redacted] mother reported that he had attacked her the previous night, punching her arm and causing bruising. [redacted] again defaulted on his outpatient appointments, but was finally seen on the third of July by Dr [redacted]. [redacted] was still experiencing psychotic symptoms. Following this [redacted] was again referred for anger management, but there was no response to their letter inviting him to the assessment.

3.22 In April 1998, there was a further incident of [redacted] throwing bricks through his mother's windows. [redacted], [redacted] support worker had been unable to make contact with him for several weeks. During this time, [redacted] had been seeing a private psychotherapist and had been prescribed tranquillisers by his GP. In June 1998, there is a report of a further assault on [redacted], when [redacted] punched her in the stomach. He then kicked her in the back, whilst wearing steel capped shoes. [redacted], his CPN expressed concerns for [redacted] safety. On 28 July 1998, [redacted] visited [redacted] and found him to be talking rationally. He believed that television was filming him, and

that he was getting abuse from other people. He also asked the support worker, whether he thought he ([redacted]) should kill himself. On the 14th of August, [redacted] was seen by Dr [redacted], who was concerned about the non-compliance with medication, the assaults on his mother, and [redacted] mental state. Following this consultation, [redacted] was admitted under section 3 (MHA).

3.23 Fifth Admission

On admission, [redacted] appeared depressed and thought disordered. He was recommenced on medication. Early in the admission he absconded frequently and returned having consumed alcohol to the point of intoxication. Following the ward round on 24 August, [redacted] appeared very angry, kicking the doors and throwing furniture. He voiced threats towards Dr [redacted] and expressed a wish to leave the ward. On the 21st of September, another patient reported that [redacted] had been smoking cannabis, with another patient. On the 26 of September, [redacted] became angry during a visit by his father and he pushed his father and kicked furniture around. On 26 October 1998, Dr [redacted] considered prescribing a depot medication or clozapine (an anti-psychotic for treatment resistant psychosis). Later that evening, [redacted] set light to an artificial plant. He was unable to understand the risks in this posed.
In December of that year, [redacted] again started leaving the ward and consuming alcohol.

3.24 On 15 February 1999. It was reported that there had been further violent episode, when [redacted] had thrown a cup of hot tea over another patient. He was also refusing clozapine, but was by then accepting depot medication. He was finally discharged from hospital on 13 August 1999 on a supervised discharge order (S25(a)MHA 1983).

3.25 On 27 August, [redacted] failed to turn up for his depot medication following contact with his mother. He also failed to attend appointments on 1 September, and again on 8 September. He was reviewed on 23 September, when the plan was to reduce his depot medication and introduce another anti-psychotic. He attended outpatients the following month, when it was reported that he was doing well. During this period, he was also being seen by [redacted], CPN, who was providing both [redacted], and his mother, with support and advice. During the early part of 2000, [redacted] appeared to be more compliant with appointments but took his oral medication, somewhat erratically.

3.26 Admission to The Old Vicarage, residential services.

[redacted] mental state remained unstable and changeable, throughout 2000. In January 2001 it was noted that the side effects of medication were prominent, despite the regular use of an anti-cholinergic. It had been noted sometime earlier that there was evidence of oral facial dyskinesia (involuntary abnormal muscle movements). [redacted] stated that he was willing to try clozapine, and he agreed to a short admission to hospital, in order for this to be commenced. He was admitted to the Old Vicarage, on

the 31 January, where he remained until 28 February, following successful introduction of clozapine.

3.27 There were some initial problems following discharge with a degree of postural hypotension. [redacted] was compliant with the required blood testing and self-administered medication using a dosette box. By August 2001 [redacted] compliance was less regular with both blood tests and collecting medication. [redacted] was receiving support from social worker befriender, CPN and support worker as well as having his sister, helping to keep his flat clean. [redacted] was often out, or unwilling to answer when members of the support team called to deliver his medication. There were often a number of tablets left in the used dosette box.

3.28 On 18 January 2002 [redacted] was visited at home. His flat was, untidy, and there were empty cans of strong lager on the floor. [redacted] had heard the news that his befriender had died recently, and proposed to attend the funeral.

3.29 In March 2002 there was increased evidence of cannabis use, along with alcohol. On the 19th of March a meeting was held to discuss [redacted] poor compliance and it was proposed that he take his medication in a once daily dose. Despite this, and a discussion regarding the safety aspects of clozapine with [redacted] from the AOT, [redacted] compliance remained poor. On number of occasions, medication had to be re-titrated due to periods of non-compliance.

3.30 [redacted] attempted to introduce [redacted] to various social activities, with little success. He did, however, join the MIND bowling group, which he appeared to enjoy.

3.31 In November 2002 [redacted] reported having thoughts of the devil, and thought that he might speak to a priest about this. He was advised to speak to his CPN. However, [redacted] was reluctant to consider a further admission to hospital. On 31 January 2003, there was evidence in his flat of cannabis use. [redacted] showed some increased signs of paranoia and auditory hallucinations.

3.32 A CPA meeting was held on 7 July 2003. Various matters were discussed including day-care, maintaining input of professionals, moderating [redacted] alcohol intake and increasing his engagement. Dr [redacted] discharged [redacted] from section 25 (a) (MHA).

3.33 Throughout the remainder of 2003 - 2004 contacts with [redacted] were intermittent, usually due to [redacted] being asleep or out. On the occasions when access was possible his flat appeared untidy and chaotic.

3.34 A comprehensive risk assessment and management plan completed on the 22nd of November 2004. This was the last recorded entry in [redacted] case notes.

Chapter Four

4. The incident

The evidence collected after the event would suggest that on the morning of the incident, [redacted] had walked barefoot from home to [redacted] flat. He was wearing only boxer shorts and a dressing gown, suggesting that he got up from bed and left the house at an early hour. He had arrived at the flat at 6:00am on 2 December 2004. [redacted] opened the door, and a frenzied attack took place with [redacted] being backed into the bathroom, where he died. [redacted] then used the same hunting knife to cut his own throat. He was found by another service user, dying outside the door. Prior to this he had been observed through the glass panel in the door, pacing up and down inside [redacted] flat. Another resident in the block of flats raised the alarm.

Chapter Five
5. OVERVIEW OF SERVICES

5.1 General Practitioner

Both men were in receipt of services from local general practitioners. Dr [redacted] was [redacted] family GP and had also been [redacted] GP throughout. Dr [redacted] had been [redacted] GP, whilst he was living in [redacted]. Both GPs were aware of the mental health problems of their respective patients and had a role in providing repeat prescriptions and general medical services to both men. Appropriate referrals had been made to psychiatric services when these were warranted. Both GPs were kept informed of their patients' progress or failure to attend appointments via letter.

Although neither GP was invited to the critical incident review, neither had any thing to add to the review documentation.

5.2 Hampshire Partnership NHS Trust

5.2.1 Consultant Psychiatrists.

At the time of the incident, Dr [redacted] was the consultant psychiatrist in charge of the care of both men. Dr [redacted] took up his post as consultant psychiatrist in August 2003. [redacted] had been known to services since 1993 when he had been seen by Dr [redacted], whilst he was working as a locum consultant at [redacted]. [redacted] had originally been referred to Dr [redacted] and was under his care in the period until 2003. Prior to August 2003, [redacted] had also been seen by two other consultants, Dr [redacted] and Dr [redacted].

[redacted] had been under the care initially, of Dr [redacted] and subsequently, of Dr [redacted].

On the whole in both patients' cases there was good continuity of consultant care, with evidence of good communication between the consultant and other members of the multidisciplinary team.

5.2.2 Community Psychiatric Nursing Staff

Both men had a variety of CPN input over the period they were involved with services. The CPNs varied their level of input according to the prevailing circumstances, increasing their support at times of crisis or relapse. The community staff also appeared to engage with the families of the two men, receiving telephone calls and giving support and advice.

Documentation by the community staff was contemporaneous and brief, but covered all necessary detail so that other members of the team were aware of the current situation.

Staff were willing to be persistent even in the face of unwillingness on [redacted] part to engage and to continue to visit despite numerous abortive visits.

[redacted] was in regular contact with [redacted] and these contacts are recorded in the medical records.

5.2.3 Support Workers

There was support worker time allocated to [redacted] who was living alone at various times. The workers were to help with activities of daily living such as maintaining the tidiness of his environment, shopping and self-care. They, too, were persistent in the face of [redacted] attempts to disengage and his obvious negative symptoms, compounded by the cannabis and alcohol use.
[redacted] had been offered support worker input, which he had declined.

5.2.4 Social Workers.

Approved Social Workers were involved at the times when Mental Health Act assessments were undertaken.

5.2.5 Assertive Outreach Team

In the case of [redacted] the AOT were involved because of his propensity to disengage. [redacted] and his CPN colleagues tried to maintain regular contact with [redacted] and to engage him with Occupational Therapy and community based activities. They were instrumental in ensuring that he received his supplies of clozapine, that it was appropriately monitored, and that he complied with the treatment, as fully as they were able.

5.2.6 Psychologists

There had been psychology input to both men and also some family work with [redacted] family. The psychology input was appropriate and timely. There was good communication between the psychologists and the rest of the multidisciplinary team. [redacted] was seen early in his illness for anxiety management and later for anger management while [redacted] was seen originally in his teens for psychological assessment and input. Later the whole family was seen for family intervention.

5.3 Private Psychotherapy

[redacted] was seen for some time by a private psychotherapist. It is always a difficulty when patients, who are under the care of local services, see private counsellors or therapists who have little or no contact with the rest of the care team. This may cause confusion for the patient, increase the chances of splitting and at worst prevent the sharing of vital information regarding the patient's mental state or risks being posed to or by the patient. There is also the risk that if the therapist is unaware of the patient's diagnosis, that some forms of therapy detrimental to the patient's mental state may be undertaken.

Chapter Six
6. Observations of Good Practice

6.1 The later version of joint care plan for enhanced patients was clear, concise and easy to follow. It contains a tick box format where much relevant information can be recorded within a compact form with sufficient space for free text.

6.2 The Joint Risk Assessment and Management Plan (version 3) provides comprehensive information and dated entries evidencing risks. This provides an evolving risk assessment without the loss of historical information whilst adding new risks as they arise. It provides a more helpful assessment than those forms, which take a static, snapshot view of risk.

6.3 The use of joint health and social services integrated records allows for better information sharing. Information held by either service is accessible to the other. The potential for incidents is greatly reduced, as all personnel working with a patient are aware of the risks and the interventions other colleagues are undertaking.

6.4 The system of computerised entries recorded with dates, and names of personnel involved, provides an up to date record of contacts.

6.5 There is good evidence of multidisciplinary and multi-agency input to [redacted] care.

Chapter Seven
7. Recommendations

7.1 *Recommendation 1.*

CPA policy

The CPA policy in use in December 2004 is brief, and only a broad outline of the CPA process. There is no policy around action to be taken when patients start to disengage. Future versions of the CPA policy should be more prescriptive in terms of the actions to be taken in particular events.

The CPA documentation used at final the CPA meeting was clear, concise and explicit. This has clearly evolved over the time that these patients were being seen.

7.2 *Recommendation 2.*

Risk assessments

Early versions of risk assessment documentation were unhelpful. Historical information was often not recorded or carried forward on updated assessments. This was particularly the case with assessments carried out on [redacted] where the episodes of violence, which occurred, involving his mother were underplayed. Inappropriate sexual behaviour, which had been noted during one of his early admissions, did not feature on any of the risk assessments. Despite [redacted], having spent a period, following his early admissions, living rough and given the chaotic and dirty state of his flat, self-neglect was not selected on any of his risk assessments. There was little formal risk assessment documented in [redacted] notes presumably because he was on standard level CPA and was not deemed to be at high risk. It would be sensible for an abbreviated version of a risk assessment to be documented even in low risk individuals to show that at least all the risks have been considered. An extended risk assessment could then be carried out where there was evidence of risk in a particular area or individual. It is unlikely that any risk assessment, however thorough would have highlighted the risk of this particular incident or something similar happening.

The later version of the risk assessment is much improved, but clearly any risk assessment is only as good as the information held by the professionals, who complete it. This version was a dynamic assessment where information was added to the existing information rather than a new assessment being filled in on each occasion the risk assessment was updated, thus preventing the loss of historical information. This form of risk assessment should continue to be used and warrants wider use in psychiatric services for the above reasons.

7.3 *Recommendation 3.*

Section 25(a) MHA 1983

At no point was [redacted] considered for a section 25(a) despite his periods of poor compliance. There would have been grounds for this given his history of violence and his lack of engagement. This would need to have been implemented during a period of detention in hospital on Section 3 (MHA 1983). [redacted] had not been

detained nor had an admission since the late 1990s.
It is recommended that consideration of section 25(a) be documented in all cases of patient's with severe and enduring mental illness who are so detained and who have a history of disengaging.

7.4 *Recommendation 4.*

Discharge of Section 25(a) MHA 1983

It would appear that perhaps Dr [redacted] may not have been familiar with [redacted] history when opting to discharge the Section 25A (MHA 1983). [redacted] was still poorly engaged with services and was intermittently non-compliant with treatment whilst still abusing cannabis and alcohol.
It is not clear how long Dr [redacted] was employed by the service or whether this was a substantive or locum post. Although Section 25(a) has limited powers it at least serves to highlight individuals who raise some cause for concern. Discharging it should not be undertaken lightly and should only be considered after extensive consultation with all involved in the patient's care, in the same way as when it is initiated. As section 25(a) can only be initiated whilst the patient is on Section 3, there are limited opportunities to instate this.
It is recommended that discharge from section 25(a)(MHA 1983) not be undertaken by locum staff or those only involved with the patient for a brief time. There should be extensive consultation before the section is discharged.

7.5 *Recommendation 5.*

The Relapsing Patient

It was clear that by the time of the incident [redacted] was disengaging and relapsing. Although it is recorded that he "was not sectionable" he had a long history of being admitted under section having behaved in a bizarre or dangerous manner. There is now a consensus that section 3 (MHA 1983) can be applied to well-known patients whose history is well documented and who pose increase risks as they relapse.
[redacted] would have fallen into this category and could have been assessed under the MHA. Had this been undertaken it might have prevented at least part this tragedy.
It is recommended that all professionals be made aware of the finer points of assessing long term patients under the Act in order to prevent serious relapse.

7.6 *Recommendation 6*

Private Psychotherapy

Although psychotherapy is sought and paid for by the individual, it is clearly confidential and undertaken either because such services are not available within the NHS or because the patient wishes to keep this aspect of their care separate from the NHS input. This may be due to the team disagreeing with such a course of action or having some other difference of opinion with the patient eg diagnosis.
It is recommended where patients who are severely mentally ill and under the long term care of an NHS

psychiatric team that some level of communication and co-operation should be sought. Even within the NHS, psychotherapy notes may be kept separately from the main clinical notes and communication may be sporadic and sparse, and this should apply equally in these occasions. In the NHS, integrated notes with a section for psychotherapy would be the ideal. Where there is private therapist involvement, regular updates should be provided and details of risk shared for the safety of all parties.

7.7 *Recommendation 7*

Assertive Outreach Team (AOT)

There is documented evidence that input from an AOT was considered for [redacted]. There was concern that this level of input might alienate [redacted]. On the other hand input from the AOT might have prevented [redacted] from discontinuing his medication and relapsing. This in turn *may* have prevented the incident occurring.

It is recommended that input from an AOT be considered in all cases where patients with serious mental illness start to disengage. The risk of alienation is probably small compared to the benefits of keeping patients as well as possible. This in turn will reduce risk as these usually increase with deterioration in mental state.

Chapter Eight
8. Conclusion

It is clear from all the evidence available, that [redacted] was mentally unwell at the time of the incident.

Although he had not been taking medication for some time he had recently recommenced and was making a slow recovery. He was willing to work with services and appeared quite honest in reporting his lack of compliance. He was felt to be a gentle person and there were no immediate concerns regarding either suicide or violence to others.

[redacted] had been disengaging with services and was regularly abusing cannabis and alcohol. He had a past history of violence both towards individuals and to inanimate objects. He had no history of using weapons other than things like furniture, which were immediately to hand.

There is little to suggest any close relationship between [redacted] and [redacted] beyond that of acquaintances. [redacted] had mentioned [redacted] in conversation about 2 years previously and both men had been brought up in the same area. Both were involved with services and would meet occasionally. There is no evidence of any more intimate relationship.

There is no possible way from the knowledge of both men and their mental states that this incident could have been predicted in either its timing or its ferocity.

Why [redacted] should have headed for [redacted] flat on that morning will never be known. Given that [redacted] was unwell at the time, it is probable that he acted in response to some psychotic phenomena, whether command hallucination or some form of delusional paranoid belief. These are questions that will remain forever unanswered with the death of both parties involved.

Given the completely unpredictable nature of this event, there is likely to be little benefit in holding a further inquiry, as it is unlikely that there would be any other conclusion. Further investigation would only prolong the distress for the family and stress for the professionals involved. There are not major shortfalls or omissions in services, which need to be addressed, and therefore no benefit in reviewing these cases again.

Appendix A

Role of the Independent Investigator

The principal functions of the Independent Investigator when undertaking an external review are as follows:

1. To ensure that the external review is conducted in accordance with the terms of reference.

2. To consider all documents sent to them in connection with the external review and to advise within their report of any action, which they consider should be taken to address issues raised by those documents.

3. To identify and meet with or discuss on the telephone individuals who are believed to be relevant to providing additional background information in respect of the external review or who were involved in the care and treatment of the patient where this is felt to be particularly relevant.

4. To prepare the final report and submit to Dr [redacted], Consultant in Public Health/Deputy Medical Director.

Abbreviations

AOT Assertive Outreach Team
ASW Approved Social Worker
CMHT Community Mental Health Team
CPA Care programme Approach
CPN Community Psychiatric Nurse
GP General Practitioner
MHA Mental health Act 1983
NHS National Health Service
SHO Senior House Officer, Doctor training in Psychiatry

SOUTHAMPTON CITY COUNCIL

Hampshire County Council
SOCIAL SERVICES

NHS *West Hampshire Trust*

INTEGRATED CARE PROGRAMME APPROACH

OVERARCHING OPERATIONAL POLICY

This policy has been developed jointly with
Southampton City Social Services Department, West Hampshire Trust and Hampshire County Council Social Services Department
Version 2 ~ July 2003

CONTENTS

1. INTRODUCTION

1.1 Introduction

The Integrated Care Programme Approach (ICPA) is fundamental to the provision of a user centred mental health service, and is a requirement by the Government of all specialist mental health services. West Hampshire NHS Trust, Hampshire County Council Social Services Department and Southampton City Social Services Department are committed to developing community care, and therefore believe that ICPA is not an optional extra, but the structure on which all treatment, care and support efforts must be built while the service user and their carers need assistance from specialist mental health services. (*"The CPA is care management for those of working age in contact with specialist mental health and social care services." Ref: Effective Care Co-ordination in Mental Health Services – Modernising the Care Programme Approach, October 1999)*

The objectives of ICPA must be understood and delivered in an integrated way by those involved from Health and Social Services, working in partnership with other statutory and voluntary agencies. This is to ensure that the ICPA process starts at the first point of contact and only ends with discharge from the services with high standards of communication being essential throughout. Repeated independent inquiries highlight the importance of accurate and timely communication. The principle is getting the right people to the right place for the right intervention at the right time (ref above).

This principle is particularly important in the case of individuals who need the support of a number of services and agencies and there are some who, as well as their mental health problem, will have a learning disability or a drug/alcohol problem. In all of these cases a co-ordinated approach from relevant agencies is essential to efficient and effective care delivery. No one service or agency is central in such a system. Service users themselves provide the focal point for care planning and delivery.

This policy describes the requirements of the ICPA setting out the processes to be followed for:

- Assessing, planning and reviewing of care
- Hospital and Community Interface
- Discharge and transfer
- Legal and statutory requirements
- Roles and Responsibilities of Care Co-ordinator
- Audit

These are national policy requirements to be followed by all professionals in every mental health service.

1.2 Lead Officer

The Trust and Social Services have jointly appointed a Lead Officer for ICPA. This person is responsible for the ICPA process as outlined in this policy document. S/he is in a position that enables them to ensure that resources are available to facilitate the smooth operation of ICPA and be responsible for regular audit and review of ICPA processes and procedures.

The process for the implementation and monitoring of these principles will be specified in local operating instructions for Hampshire and Southampton City.

1.3 Scope of ICPA

This ICPA Policy applies to all adults of working age who are accepted by specialist mental health services within the West Hampshire Trust.

The principles of the ICPA form the basis of good practice, and are therefore relevant in the care and treatment of younger and older people with mental health problems and should be applied. The use of the ICPA regarding transition of young people to AMH services and adults to EMH services is explicit within the Protocols for transition and should be undertaken in accord with this policy.

The ICPA process provides a framework for care and communication wherever service users are, including residential settings, in and out of area, prison, etc. the ICPA should not be considered simply as a framework for aftercare, nor a paper exercise, and must be utilised to ensure that those with complex needs stay in contact with services.

1.4 Components of ICPA

The ICPA has 4 main elements, which are:

1. **Systematic Holistic Assessment** of health and social care needs of the service user, and the assessment of carers needs where appropriate, together with an assessment of the degree of risk he/she represents regarding self-harm, harm to others and self-neglect.

2. **A Care Plan** (with crisis and contingency plan) including care purchased through care

management processes that has identified the health and social car required from a variety of providers that is jointly agreed with members of the multi-disciplinary team, GPs, the service user and his/her carer and other relevant agencies. The service user must be given a copy of his/her care plan.

3. **A Care Co-ordinator** appointed to keep in close contact with the service use and to monitor and co-ordinate car. This contact will be detailed within the care plan, based on the service users needs.

4. **Regular review** and monitoring of the service users needs and progress against the care plan.

These components **must** be put in place for **all service users**. The complexity of needs and risk will decide which level of ICPA the service user will be on.

1.5 ICPA Levels

There are two levels, Standard and Enhanced, which will be determined by the complexity of the persons needs and services required. However, people can move between levels as their needs change.

Characteristics of people on <u>Standard ICPA</u> will include some of the following:

- They require the support or intervention of one agency or discipline or they require only low key support from more than one agency or discipline;

- They are more able to self manage their mental health problems;
- They have an active informal support network;

- They pose little danger to themselves or others;

- They are more likely to maintain appropriate contact with services.

Characteristics of people on <u>Enhanced ICPA</u> will include some of the following:

- They have severe mental illness with multiple care needs, including housing, employment etc., requiring inter-agency co-ordination;

- They may have a care package purchased by care manager and provided by central agencies;
- They are only willing to co-operate with one professional or agency but they have multiple care needs;
- They may be in contact with a number of agencies (including the Criminal Justice System);
- They are likely to require more frequent and intensive interventions, perhaps with medication management;
- They are more likely to have mental health problems co-existing with other problems such as substance misuse;
- They are more likely to be at risk of harming themselves or others;
- They are more likely to disengage with services.
- They are more likely to have a history of self harm or violence to self or others (Ref: National Suicide Prevention Strategy for England, DOH 2002).
- They are more likely to have been detained under the M.H.A. 1983, On Section 117 after care.

1.6 Carers Assessment

The Carers Recognition and Services Act came into force on the 1st April 1996 and the provisions from this Act apply to ICPA Assessments.

This Act stated that where a local authority is carrying out an assessment of the needs of a service user, and that this service user has a carer who provides or intends to provide a substantial amount of care on a regular basis, then the carer may request that their ability to provide and continue to care be assessed. The results of this assessment then have to be taken into account in deciding about service provision to the service user.

- Carers have a right to request a separate assessment of their needs
- All professionals should be alert to the needs of carers and ensure they are enabled to have a separate

assessment and appropriate support.

The Mental Health National Framework *(Ref: HSC99/223:LAC(99)34)* also includes Standard 6, which, using the same definition of a carer, adds that:

- Carers should have an assessment of their caring, physical and mental health needs, repeated on at least an annual basis

- Carers should also have their own written Care Plan which is given to them and implemented in discussion with them.

When completing an assessment, the Care Co-ordinator will identify carers (and in particular young carers), and ensure that they are fully informed of their right to have an assessment of their needs, and how to access it. Such an assessment will then be carried out according to local arrangements. If the carer has mental health needs in their own right, consideration should be given to the care co-ordination, to respect issues of confidentiality.

2. SYSTEMATIC ASSESSMENT

2.1 Assessment Principles

Everyone who is accepted by the specialist secondary mental health services will receive **a systematic Health and Social Care Assessment**, using an agreed assessment process.

The full range of health and social care needs must be considered in an assessment including the impact of a mental health problem on the family, carers and children involved as well as vulnerability and levels of risk. The assessment will consider immediate issues as well as those that might need future assessment.

It is important to identify **need** rather than service response. All needs must be identified, including those that cannot be met. The reason for not meeting need will be identified, collected and analysed to inform service development.

2.2 Process of Needs Assessment

- Everyone accepted for a service will receive a full systematic Health and Social Care Assessment,

which will focus on factors including needs, risks and strengths. The assessment will consider all needs, including those that may be addressed through accessing Care Management monies from Social Services.

- Assessment will be carried out by one or more qualified professional staff who will explain why the assessment is being done, how the service user can participate in the process, who else is likely to be involved, and what will happen next.

- The Care Assessor will consider where to undertake the assessment, and will where possible, have regard to the wishes of the service user.

- The person being assessed will always be treated with dignity and consideration and will be as fully involved in the assessment as possible, including their signed acceptance of the assessment where possible.

- All information relating to the assessment will be recorded according to record keeping standards and filed in the patient's case file. (Refer to the joint Trust and Social Services Record Keeping Policy)

Unobtainable objectives will be collated as unmet needs. Some needs may be:

  - identified but no resource available
  - identified but implementation unaffordable
  - identified but resources not appropriately located

- Local systems will be developed to collate and disseminate unmet needs.

2.3 Principles of Assessing Risk

Risk assessment has become an essential element of good mental health practice, and is an ongoing and an essential part of the ICPA process. All members of the team, when in contact with service users, have a responsibility to consider risk screening, assessment and management as a vital part of their involvement, and the dimensions of risk, and record action appropriately. This should include risk assessment regarding the care and protection of any children (including unborn babies) and reference should be made to the Child Protection Policy.

Where risk factors have been identified the ICPA Care Plan will contain a Risk Management and Crisis/Contingency Plan. Service users on enhanced level of ICPA will require, as part of their Care Plans, Crisis and Contingency Plans; these plans form a key element of the Care Plan, and must be based on the

individual circumstances of the service user. It is good practice for users on Standard ICPA to have similar arrangements within their care plans.

2.4 Process of Risk Assessment

- Information relating to the individual's risk screening, assessment, Management Plan and/or Crisis Plan will be communicated in a timely, concise and effective manner to services and external agencies involved in his/her care and the safety of all concerned. The principles of the Data Protection Act and Caldicott Guidance will be adhered to as this information will be provided on a need to know basis.

- All service users referred will be subject to risk screening, and have a risk assessment and management plan as appropriate.

- Risk assessments will be discussed at ICPA meetings and ICPA Review meetings. All service users on Enhanced ICPA will have a "Crisis/Contingency Plan", which details action to be taken in a crisis.

- Re-assessment of risk will be conducted at any time there is a change indicating the service user to be at risk, and for reviews of ICPA.

- All information relating to risk screening, assessment, management plans and review will be recorded and stored in the patient's case notes and on appropriate IT systems.

- Communication of information to Primary Care, other agencies, and services relating to the individual's risk screening, assessment, management plan and/or Crisis Plan will conform to Trust Policy.

3. CARE PLANNING

3.1 Care Planning Principles

There will be an identified Care Co-ordinator to facilitate the development of the Care Plan.
Care Planning is the process of engagement with the service user; who will be involved in this process, and their opinions sought on their needs and other preferences on how these will be best met. It is good practice for the Care Co-ordinator to meet together with the service user prior to the ICPA meeting to gain a clear understanding of the user's views and what opinions they wish to voice, or have voiced, on their behalf at the forthcoming ICPA meeting.

All users of the service will have a Care Plan that is based on an assessment or review of needs, and will include anticipated outcomes from the Care Plan.

It may sometimes happen that a service user, or potential service user, does not wish to participate in the care planning process. It is then possible to convene a meeting and devise a Care Plan without their direct involvement. Care should be taken that the individual's human rights are respected and they should be kept informed at all stages. The management of these exceptional care plans should be fully discussed with the relevant team co-ordinator or manager who should ensure that all ethical considerations are taken into account by the care team.

The Care Plan will take account of likely risks, and will include measured indications of progress as well as steps that should be taken to prevent relapse or crisis.

Action to meet needs may not always be carried out by statutory agencies. Some needs may be more appropriately met by self-help groups, volunteers, voluntary agencies, carers or the service user themselves. The Care Co-ordinator will be responsible for ensuring the Care Plan is implemented, and monitoring the Care Plan.

The finalised Care Plan should be completed in full, signed and dated by the Care Co-ordinator and the service user. If the service user prefers not to sign it, this should be stated. The Care Co-ordinator will ensure that all professionals and the service user are given a copy of the Care Plan as well as the carer/s, in agreement with the service user.

Care plans for all people on Enhanced ICPA should have the Contingency and Crisis Plan completed. Contingency or crisis indicators and a plan of how to respond to these should be included after being discussed with the person the plan is for.

As a minimum the Crisis Plan will include:

- Who the user is most responsive to
- How to contact that person
- Previous strategies which have been successful in engaging the service user
- Any risks or alerts
- What the service user wants to happen

Care plans should be filed in a clearly designated area of the notes. Old Care Plans should be scored through, dated, and signed clearly to show it is no longer the current Care Plan.

3.2 Care Planning Meetings

All ICPA meetings and reviews will be organised and chaired by the Care Co-ordinator.

Meetings will be planned in advance, unless specific incidents give rise to the need to call one urgently. The service user will always be made aware and given prior notice of a ICPA meeting happening.

The meetings will be given a start time, a planned duration and a suitable venue (including GP's surgery, patient's home etc) which reflect the need of the service user.

Everyone involved in the Care Plan should be able to contribute to the meetings; including housing, children and families, voluntary agencies etc. In conjunction with the service user, agreement will be made as to who needs to be invited and/or contribute to the ICPA meeting. The service user's wish to bring a friend, carer or advocate should always be respected. It is the Care Co-ordinator's responsibility to obtain and present the views of those not present.

Copies of the agreed Care Plan, Crisis Plan and information regarding the planned date, time and venue of the next ICPA meeting will be circulated to all those involved in providing care.

4. REVIEW

4.1 Review Principles

The purpose of the review is to:

- Assess the needs of the service user
- Assess the effectiveness of the Care Plan
- Amend the Care Plan as necessary and review purchased care package
- Amend the Crisis Plan as necessary
- Discharge the service user from Section under the Mental Health Act 1983 (including Section 117) N.B. In accordance with Social Services Policy.
- Discharge the service user from the service when appropriate

Care Plans will be reviewed and evaluated on an ongoing basis to monitor progress in meeting needs. The needs of people with mental health problems can change rapidly, and it is important that planned reviews are carried out. Review meetings should be brought forward if there is a marked and unexpected change

in the service user's situation, or if there is a marked divergence from the Care Plan. All service users should have one Care Plan review per year as a minimum, where needs remain unchanged. All those involved have a responsibility to ensure the Care Co-ordinator is advised of any such problems or issues that they observe, and to ensure that an appropriate review meeting is arranged to discuss them.

The review meeting will be planned in advance and is for everyone involved in providing the Care Plan. It is a shared process in which everyone's opinion, need for information, and opportunities for choice are respected. The number of people attending the review will depend on the complexity of the individual's situation, but should never be overwhelming to the service user.

4.2 Review Process

- Progress, successes and failures of the Care Plan are monitored by the Care Co-ordinator, who must have contact with those contributing to the Care Plan. The service user is central to the review process – every care should be taken to ensure that their views and wishes are reflected in the plan.

- At each review meeting the date of the next review must be set and recorded.

- Any member of the care team, the service user, or carer are able to ask for a review at any time. All requests for a review of the Care Plan must be considered by the care team. If the team decide that a review is not necessary the reason must be recorded.

- Reviews will be planned by the Care Co-ordinator. Service users should be consulted by the Care Co-ordinator prior to the review meeting, and the Care Plan redrafted for discussion at their meeting.

- ICPA reviews should be held and recorded according to documentation and policy in line with the process set out in the ICPA meeting.

- The review will include a re-assessment of:
    - the need for new objectives
    - the need to continue the Care Plan
    - the need to continue/change any purchased care package
    - the need to continue/change the Crisis Plan
    - the service user's legal status (i.e. Section 117)
    - any needs of the person concerned which cannot be met
    - discharge/transfer

- The Care Co-ordinator should call an urgent review meeting as soon as possible, if:
    - the person wishes to withdraw from their Care Plan or part of it.
    - the service user discharges themselves against medical advice, or threatens to do so.
    - there are specific circumstances where informal carers/relatives should be told if they are likely to be exposed to violent behaviour.
    - there is rapid deterioration in mental state.
    - there are changes in carer circumstances.

- After everyone has contributed to the review, either in person, in writing, or by phone, progress should be identified and the Care Plan revised listing the new plan in accordance with documentation and process of Care Planning.

- If it is decided to discharge the person from the service, then clear reasons must be documented and agreed.

- Part of the annual audit of ICPA will check that reviews of the Care Plan have been carried out.

5. HOSPITAL AND COMMUNITY INTERFACE

5.1 Principle:

For known service users in-patient admissions need to be seen as part of a continuation of care which usually begins and ends, not in a hospital, but in the community with the specialist CMHT. The Care Co-ordinator retains responsibility for maintaining or initiating the ICPA process whilst the service user is an in-patient. The principle of planning discharge from the point of admission must be adhered to, and to maintain continuity between hospital and community the following process will be implemented.

5.2 Process:

- On admission the admitting Nurse will establish whether the service user is already known to the Mental Health Service and/or Alcohol or Drugs Service by contacting the appropriate CMHT, or by accessing available IT systems

- On receipt of this information, the CMHT will ensure that:
    - if known service user – the Care Co-ordinator is informed (or in their absence, a locum Care Co-ordinator is identified)
    - if unknown service user – a Care Co-ordinator is allocated at the next available allocation meeting or earlier if necessary
    - if urgent intervention is required – it will be provided via the CMHT Duty System or the Team Leader, dependent on local procedures.

- When the Named Nurse is allocated, they will work with the Care Co-ordinator and service user to co-ordinate in-patient care with the ICPA process. It is expected that Care Co-ordinators will maintain regular contact with in-patients and the Named Nurses to ensure continuity of care, and this will occur on a weekly basis as a minimum. Each contact made by the Care Co-ordinator must be recorded in the service user's in-patient and community case notes (by the Named Nurse). The Named nurse/nurse in charge is responsible for ensuring that the Care Co-ordinator is consulted regarding home leave in advance of leave being taken, and that this forms part of the Care plan, including arrangements for Care Co-ordinator/CMHT involvement during the period of leave.

5.3 Discharge from Hospital

The Care Co-ordinator and the Named Nurse are responsible for co-ordinating the discharge, via the ICPA process. An ICPA Discharge Planning meeting will be held that will always involve relevant members of the multi-disciplinary In-Patient Team, the user and carer, and other agencies as appropriate to the needs of the individual, as identified in the Assessment and Care Planning process.

- No service user will be discharged from hospital without a Care Plan and named Care Co-ordinator being allocated.

- Any existing Care Plan must be reviewed to ensure appropriateness on discharge.

- All service users discharged from in-patient services will be subject to ICPA, the level of which will

be established based on criteria identified in 1.4 of this policy – until a review of this is completed in the community

- Copies of the ICPA (Section 117 information where appropriate) will be circulated to all involved parties

- Patients at risk of suicide and/or violence to self or others must receive a follow up appointment or visit within 7 days of discharge by a mental health professional. It is good practice for all other discharged patients to receive follow up to this standard.

6. DISCHARGE/TRANSFER

When discharging or transferring a person's Care Plan - clear, accurate, and timely communication with all involved is essential.

The Care Co-ordinator is responsible for ensuring that the responsibility for the care and treatment of the service user is formally transferred in a rapid, accurate and secure way to the receiving services; from whom confirmation will be required, either by attendance at the ICPA transfer meeting, or in writing.

When discharge/transfer is felt appropriate the Care Co-ordinator is responsible for arranging a meeting which should be attended by all relevant people and a representative from the receiving service.

Reasons for discharge/transfer should be clearly documented and noted on the relevant forms and in the service user's care notes.

When a service user moves to another health provider unit, the RMO and Care Co-ordinator are responsible for ensuring that the information from the case notes are transferred to and accepted by the new provider unit.

- The service user will be informed of their new RMO Named Nurse and Care Co-ordinator before transfer.

- Until such confirmation is received, care of the service user remains the responsibility of the previous service.

- If the Care Co-ordinator encounters difficulties securing responses from people involved in the transfer, then this should be reported to their line manager.

- Information systems will be updated of any discharges and transfers in and out of the service.

7. LEGAL REQUIREMENTS

7.1 Section 117

Health and Social Services have a formal and statutory duty under Section 117 of the Mental Health Act

1983 to provide after-care services for people who have been detained in hospital under Section 3, 37, 47, or 48 of the Act.

Information will be collected to ensure that all service users subject to Section 117 are known and their status in relation to this Section is regularly reviewed and recorded, as part of the ICPA process. After-care services must be continued until such time as both Health and Social Services are satisfied that the person concerned is no longer in need of such services. Review of Section 117 will be undertaken as part of ICPA Review Process and documented as appropriate.

7.2 Supervision Register

As part of on-going assessment and review, service users will be screened for inclusion on the supervision register, where significant risk factors have been identified. A decision is taken by the Consultant Psychiatrist following discussion with other team members, and based on detail gathered through the risk assessment process. This will include evidence about the service users psychiatric and social history, and current condition (including available evidence from any criminal justice agencies with which they have been involved).

The following criteria must be met:

- The service user is aged 16 years or over
- The service user has been accepted by the Specialist Mental Health Service
- There is an Integrated Care Programme in place
- The service user is suffering from a mental illness
- The service user is, or is liable to be, at significant risk of suicide, severe self neglect, or serious violence to others, and there must be a specific foreseeable circumstance in which the risk behaviour will arise.

N.B. Within local specialist mental health services, the consultant psychatrists consider ‘significant risk of

serious violence to others' to be the main criteria. In exceptional circumstances, service users who are at risk of significant self harm or self neglect may be considered for inclusion.

There will be local procedures for implementing the supervision register.

7.3 Section 25A:

Section 25A is Supervised Discharge, which will be managed through the ICPA process. Where someone is subject to Section 25A, the following is required:

- A professionally qualified (Senior RMN or ASW) team member will be the Section 25A Supervisor, and the Care Co-ordinator. *(Ref: MHA 1983 – Code of Practice, March 1999 – para 28.4)*

- A very detailed (robust) Enhanced ICPA Care Plan– with full crisis and contingency plan – will be in place and the Care Co-ordinator will be responsible for monitoring the Care Plan through the ICPA process.

7.4 Guardianship - Section 7 and 37 of MHA 1983

Guardianship provides a legal framework for a mentally disordered person over the age of 16 to help them remain in the community with a structured Care Plan, where the alternative would be admission to hospital.

Guardianship remains in force for 6 months and may be renewed for a further 6 months and then by periods of a year at a time.

It is essential that any person subject to Guardianship has the Social Worker responsible for Guardianship involved in the Care Planning and meetings.

7.5 Conditional Discharge of Restricted Patients

Conditional Discharge applies to people who were in hospital under a Restriction Order and are conditionally discharged.

Service users who have been Conditionally Discharged have to be subject to S117 and will be subject to Enhanced ICPA.

The Social Supervisor in these cases will be a qualified professional from the Probation Service or Social Services. Such a person could also become the Care Co-ordinator. Where they do not, the Social Supervisor and Care Co-ordinator will work in partnership.

The considerations for after-care in the case of a service user who has offended is that the circumstances of any victim and their families should be taken into account when deciding where the patient should live.

7.6 Care of Prisoners

The ICPA also applies to people who suffer from mental health problems within the Criminal Justice System. Where service users are the shared responsibility of mental health and criminal justice systems, close liaison and effective communication over care arrangements, including on-going risk assessment and management, are essential.

If service users have to reside in prison and they are known to have longer term and complex mental health needs, the responsible psychiatric team will maintain contact with the individual and make plans for care on the person's release, in collaboration with prison and probation staff as appropriate.

8. HoNOS - OUTCOME TOOLS

The standard measurement of clinical outcomes for all service users accepted onto ICPA will be through the use of HoNOS (Health of the National Outcome Scales). The primary purpose of HoNOS is a tool for the individual professional, and as such, the results should be scrutinised at ICPA Review meetings as a means to the provision of effective care to the user. HoNOS results should be recorded on the ICPA Paperwork, or in the service user's case notes.

9. CARE CO-ORDINATOR ROLES & RESPONSIBILITIES

9.1 Role:

The Care Co-ordinator role, for the purposes of the ICPA, will be undertaken by the person who is best placed to oversee care planning and resource allocation. The Care Co-ordinator is responsible for keeping in close contact with the service user, and for advising the other members of the care team of changes in circumstances of the service user which might require review or modification of the care plan. Where the service user has standard needs and sees just one professional, the role of the Care Co-ordinator should fall to this professional.

It is critical that the Care Co-ordinator should have the competence and authority to co-ordinate the delivery of the care plan and that this is respected by all that are involved in delivering it, regardless of agency of origin. It is also essential that the Care Co-ordinator can understand and respond to the specific needs of the service user that may relate to their cultural or ethnic background.

The Care Co-ordinator will;

- Hold a recognised professional qualification and be in the direct employment of either the Trust or Social Services.

- Have sufficient and appropriate skills to conduct the ICPA Process as agreed by themselves in discussion with the service user and the multi-disciplinary team.

- Be responsible for engaging the service user in the holistic assessment of needs and empowering the service user by informing them of the process and encouraging the service user to express their wishes in regards to ICPA and by drafting a care plan with the service user prior to ICPA meetings.

- Be named as the lead co-ordinator of care – and all agencies involved will agree to this.

- Act as liaison and, in an engaging capacity with Health, Social Services, Housing and with other statutory and non-statutory services, to fulfil the requirements of the assessment, specified plan and reviews.

- Be responsible for initiating, promoting and ensuring that effective and efficient communication is maintained in the interests of the service user's care.

- Have responsibility for undertaking and/or co-ordinating the assessment, planning, implementation and review of the care delivered to the user and their significant carer.

- Ensure that written records relating to the ICPA documentation of their client are maintained to specific standards.

- Be provided with the appropriate support/supervision mechanisms within their role.

9.2 Responsibilities:

The Care Co-ordinator is responsible for ensuring that:

- Each user who is referred to the specialist services of the Trust and Social Services has:
    - A health and social needs assessment covering the need for a Carers Assessment
    - A risk assessment and management plan, including Crisis Plan
    - A programme of care in place that is reflective of the needs identified and any unmet needs
    - Care reviewed in line with the ICPA review process.

- Following a period of initial referral and assessment identify and recommend to the multi-disciplinary team the appropriate level of ICPA.

- Dates and venues for reviews and subsequent reviews are primarily at a time and place convenient to the user/carer.

- All written documentation and verbal communication pertinent to the implementation of care are:
    - maintained to agreed standards
    - distributed effectively and appropriately to all parties involved in the ICPA
    - held and stored in a confidential manner

- Contact and communication is established, maintained and co-ordinated with the Named Nurse, if the service user is admitted to hospital or other services within or outside of the Trusts' specialist services.

- The service user is aware of:
    - the rationale for the ICPA
    - the name and responsibilities of their Care Co-ordinator
    - their right to have access to written and electronically held information about them
    - how to complain

- The service user's identified General Practitioner is aware of the identified Care Co-ordinator and relevant contact points.

- Regular contact is maintained with the service user and carer and other professionals to monitor progress.

- A named point of contact is identified to the user/carer and other professionals in the absence of the

allocated Care Co-ordinator, thus ensuring continuity of care.

- The service user has the opportunity to contribute to the evaluation of the Trust services, the ICPA process and related identified professional roles.

N.B: ***Whilst holding the above responsibilities it is important that the Care Co-ordinator is acting as the representative of other key professionals involved in the service user's care. As such this does not mean that the Care Co-ordinator is taking absolute and sole responsibility for the delivery of individual elements of the treatment and care of the user.***

9.3 Deputising/Covering arrangement

It is essential that when the Care Co-ordinator is absent for any length of time, that there is another named member of staff (a 'buddy') to take over the fundamental aspects of the Care Co-ordinator's role, and to provide continuity and seamless care.

10. LOCAL ICPA MANAGEMENT:

This role has been devolved to operational team management level.

The team manager or service leaders are responsible for the day to day management of the ICPA in their areas, and they are accountable for its effective implementation, including new developments. They are responsible for the documentation being auditable, to include all the appropriate documentation for ICPA.

The operational team manager (service leader) or the clinical lead will be the person that facilitates and negotiates between professionals, where there is a fundamental and clinically based disagreement with the Care Plan.

Managers should ensure that the balances between service users and their carers' rights and involvement are maintained consistently.

Minimum standards for the ICPA information will be responsibility of the Team Manager to monitor.

11. AUDIT

Principles and process:

Audit and monitoring are essential components of successful implementation of the ICPA. The ICPA will be audited through:

- a localised Directorate programme of clinical audit focusing on the quality of the ICPA will be implemented in each team, aligned to the National Audit tool. The responsibility for audit lies with the Lead Officer for ICPA.

12. REVIEW

This policy is subject to at least annual review, led by the Lead Officer for ICPA within the West Hants Trust.

[redacted]

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